Availability and Structure of Ambulatory Rehabilitation Services: A Survey of Hospitals with Designated Rehabilitation Beds in Ontario, Canada

Michel D. Landry, Laura A. Passalent, Cheryl A. Cott

ABSTRACT

Purpose: To determine the degree to which ambulatory physical therapy (PT), occupational therapy (OT), and speech language pathology (SLP) services are available in hospitals with designated rehabilitation beds (DRBs) in Ontario, and to explore the structure of delivery and funding among services that exist.
Methods: Questions regarding ambulatory services were included in the System Integration and Change (SIC) survey sent to all hospitals participating in the *Hospital Report 2005: Rehabilitation* initiative.
Results: The response rate was 75.9% (41 of 54 hospitals). All hospitals surveyed provide some degree of ambulatory rehabilitation services, but the nature of these services varies according to rehabilitation client groups (RCGs). The majority of hospitals continue to deliver services through their employees rather than by contracting out or by creating for-profit subsidiary clinics, but an increasing proportion is accessing private sources to finance ambulatory services.
Conclusions: Most hospitals with DRBs provide some degree of ambulatory rehabilitation services. Privatization of delivery is not widespread in these facilities.

Key Words: access, ambulatory services, hospitals, hospital report card, rehabilitation

Landry MD, Passalent LA, Cott CA. Availability and structure of ambulatory rehabilitation services: A survey of hospitals with designated rehabilitation beds in Ontario, Canada. Physiother Can. 2008;60:246-254.

RÉSUMÉ

Objet : Déterminer le degré de disponibilité des soins ambulatoires de physiothérapie, d'ergothérapie et d'orthophonie dans les hôpitaux ayant des lits de réadaptation désignés en Ontario ; explorer la structure de prestation et de financement des soins offerts.
Méthodologie : Des questions concernant les soins ambulatoires ont été incluses dans le sondage sur l'intégration et le changement du système qui a été envoyé à tous les hôpitaux participants dans le cadre du *Rapport de 2005 sur les hôpitaux : Réadaptation*.
Résultats : Le taux de réponse a été de 75,9 % (41 des 54 hôpitaux). Tous les hôpitaux sondés assurent la prestation de soins ambulatoires de réadaptation à un certain degré, mais la nature de ces soins varie selon le groupe client en réadaptation. La majorité des hôpitaux continue d'assurer la prestation de soins par l'intermédiaire de leurs employés plutôt que de recourir à des sous-traitants ou de créer des cliniques subsidiaires à but lucratif, mais une proportion croissante accède à des sources privées pour le financement des soins ambulatoires.
Conclusion : La plupart des hôpitaux ayant des lits de réadaptation désignés fournissent des soins de réadaptation ambulatoires à un certain degré. La privatisation de la prestation n'est pas très étendue à ces installations.

Mots clés : accès, soins ambulatoires, hôpitaux, bulletins des hôpitaux, réadaptation

Michel D. Landry, PT, PhD: Assistant Professor, Department of Physical Therapy, University of Toronto, Toronto, Ontario; Adjunct Assistant Professor, Department of Health Policy and Administration, University of North Carolina at Chapel Hill, Chapel Hill, North Carolina. At the time of this study, Dr. Landry was a post-doctoral fellow with the Arthritis Community Research and Evaluation Unit (ACREU) and the Toronto Rehabilitation Institute (TRI).

Laura A. Passalent, PT, MHSc: Research Associate, Arthritis Community Research and Evaluation Unit, Toronto, Ontario; Lecturer, Department of Physical Therapy, University of Toronto, Toronto, Ontario.

Cheryl A. Cott, PT, PhD: Associate Professor, Department of Physical Therapy, University of Toronto, Toronto, Ontario; Deputy Director, Arthritis Community Research and Evaluation Unit (ACREU), Toronto, Ontario.

Funding for this study was provided by the Hospital Report Research Collaborative, University of Toronto.

Conflicts of Interest: None.

The authors thank all participating hospitals for their time and efforts in completing the survey, and Mayilee Canizares from the Arthritis Community Research and Evaluation Unit (ACREU) at the University Health Network for statistical analysis. Michel D. Landry is supported through a Career Scientist Award from the Ontario Ministry of Health and Long-Term Care.

Address correspondence to *Dr. Michel D. Landry*, Department of Physical Therapy, University of Toronto, 160-500 University Ave., Toronto, ON M5G 1V7 Canada; Tel: (416) 946-8560; Fax: (416) 946-8562; E-mail: mike.landry@utoronto.ca.

DOI:10.3138/physio.60.3.246

INTRODUCTION

Access to health services remains a highly political issue across Canada, and much of the rhetoric focuses on the Canada Health Act (CHA).[1,2] The CHA has become a paradox in Canada's health care landscape: some perceive it as a protector of the nation's single-payer, publicly funded and privately-delivered health care system;[3,4] at the same time, others view it as an institutional barrier to developing a more progressive health system that meets the current needs of Canadians.[5,6] As might be predicted, stakeholders and political pressure groups use the language of the CHA, and their perception of its intent, to defend their particular ideologies against other competing interests.

A more in-depth review of the limits of the CHA has been reported by others and will not be fully addressed here.[4,7,8] However, it is essential to note that the CHA defines the terms and conditions of an ''insured'' service across all Canadian jurisdictions. For instance, the ''comprehensiveness'' condition defines an insured service in terms of *who* delivers it and *where* it is delivered. In this case, the ''who'' implies physicians, and the ''where'' implies hospitals. Thus, in order to remain eligible for federal cash transfers and tax credits, provincial health plans need only provide medically necessary physician and hospital services; provinces and territories can, but are not legally forced to, insure or deliver care beyond these institutional boundaries.[4] All other services, including medically necessary services outside of hospitals, such as home care, rehabilitation services, and prescription drugs, are beyond the institutional and structural limits of the CHA. Thus, although this may not have been the original intent, rehabilitation services (especially outpatient and ambulatory community services) are generally beyond the insurable limits of the CHA.[9]

Rehabilitation providers across Canada may believe, and assume, that their services are medically necessary to the health of Canadians; however, other stakeholders do not necessarily share this view, especially when decision makers operate in an environment of economic scarcity. As a result, the availability of hospital-based rehabilitation services, and outpatient and ambulatory services in particular, appears to be increasingly eroded. Moreover, the structure of those services that remain appears to be shifting as finances move toward the private sector,[2] and these services are also gradually coming to be delivered through a mix of small and large private for-profit providers.[9] In 2007, the Ontario Physiotherapy Association (OPA) reported that an increasingly large number of hospitals across the province had privatized the delivery of PT services; the association voiced concern that this ''has led to a crisis in access to needed physiotherapy services.''[10] However, the extent to which these changes to hospital-based rehabilitation services have occurred across Ontario and the effects that they may have on financing and delivery of rehabilitation services have not yet been fully explored.

The purpose of this research was to explore outpatient or ambulatory rehabilitation services provided through Ontario's network of hospitals with designated rehabilitation beds (DRBs). The primary objective of the study was to explore the availability of outpatient rehabilitation services provided; the secondary objective was to explore the structure of delivery and funding.

BACKGROUND

The study was conducted as part of the *2005 Hospital Report: Rehabilitation,* a province-wide initiative conducted by the Hospital Report Research Collaborative (HRRC) that uses a balanced scorecard approach to collect quality indicators for hospitals with DRBs. The HRRC is an independent research collaborative whose mandate is ''to conduct research and engage Ontario hospitals in performance measurement and management activities.''[11] The Ontario Hospital Association (OHA) and the Ontario Ministry of Health and Long-Term Care (MOHLTC) have provided significant funding and support for these research activities. The original Hospital Reports focused on acute care, but the initiative has expanded to include emergency departments, complex continuing care, rehabilitation, and mental health. The overall objectives of the Hospital Reports are (1) to strengthen accountability by providing performance information to a diverse group of stakeholders, including Ontario citizens, hospital administrators, managers, care providers, and policy makers; (2) to support quality-improvement efforts in facilities and programmes; and (3) to support the collection, standardization, and comparability of data available to diverse programmes and services.

To date, there have been three instalments of the *Hospital Report: Rehabilitation.*[11–13] These reports evaluate the operations of hospitals with DRBs using a balanced scorecard approach that examines performance across four quadrants: Clinical Utilization and Outcomes (elements of clinical success), Client Perspectives (dimensions of care that are most relevant to clients), Financial Performance and Condition, and System Integration and Change (SIC) (the changes and investments facilities need to make in order to move ahead in the next three to five years). DRBs are designated hospital beds earmarked specifically for rehabilitation purposes by the MOHLTC.[11] An important limitation of earlier reports was that only hospitals with DRBs, and only in-patient rehabilitation services, were included, which limited the scope of analysis.[12] In order to address this limitation, the *2005 Hospital Report: Rehabilitation*

Table 1 Study Measures/Variables

Measure	*Operational Definition of the Variable*	*Response Options*
Rehabilitation client groups (RCGs)	RCGs are groupings of clients with similar impairments, activity limitations, and participation restrictions. Respondents were instructed to complete a survey form for each RCGs applicable to their setting. There was no strict definition as to which diagnostic codes were included in each RCG.	• Stroke • Orthopaedic conditions • Brain dysfunction • Spinal cord dysfunction • Neurological conditions • Amputations of the limbs • Arthritis • Pain syndromes • Cardiac • Pulmonary • Burns • Congenital deformities • Other disabling impairments • Major multiple trauma • Developmental disabilities • Debility • Medically complex *Note:* Only the Stroke, Orthopaedic, and Brain Dysfunction RCGs were used in the analysis.
Availability/Setting	The setting variable for this study was defined as the extent to which ambulatory rehabilitation services were available. If services were available, the respondent was then asked in what specific setting these services were provided.	Availability: • Yes • No Setting: • Outpatient Department (OPD) • Day hospital (DH) • Combination of OPD + DH • Service not provided
Employment structure	The survey asked about the employment structure of health professionals providing direct rehabilitation services. This variable explored the extent to which hospitals decided to provide services through their employees or by contracting out services to an external provider, as well as the degree to which hospitals may have created internal for-profit subsidiary clinics within their institutions.	Employment: • Employees (E) • Subsidiary clinic (S) • Contracted out (CO) • Combination of E + S • Combination of E + CO • Combination of S + CO • Combination of E + S + CO
Types of funding	This question asked which funding sources were accessed for specific disciplines for each RCG. Hospitals were asked to include all public and private funding sources accessed to finance ambulatory or outpatient rehabilitation services.	Public Sources • Hospital global budget • Veterans Affairs Canada (VAC) Private Sources • Motor vehicle accident (MVA) insurance • Workplace Safety & Insurance Board (WSIB) • Extended Health Benefits (Ext Health) • Out-of-pocket payments (OOP) • Assistive Device Programme (Ass Dev) • Other (open-ended)
Access criteria	This question was open ended and asked the respondent to provide details regarding the hospital's access criteria for high-priority and low-priority clients.	Access: • Open-ended question
Wait times	Although access to ambulatory rehabilitation services may or may not be considered an entitlement under the Canada Health Act, waiting time for these services is critical for individuals who are considered to be high and/or low priority. This open-ended question asked the respondent to provide details regarding the hospital wait-time definition for high-priority and low-priority clients.	Wait Times • Open-ended question (data were recoded into # of weeks)

included a series of questions that addressed rehabilitation services beyond the inpatient setting, and specifically ambulatory services.[13] Data collection for the SIC quadrant in 2005 included questions that asked hospitals with DRBs to describe the availability, structure, and funding of ambulatory rehabilitation services for clients according to rehabilitation client groups (RCGs) as defined by the National Rehabilitation Reporting System (NRS). Unlike acute-care clients, who are classified at discharge according to diagnostic codes, each client in the NRS is classified into an RCG, which includes those with impairments, activity limitations, and/or participation restrictions associated with 17 groupings (see Table 1). This article describes the findings in terms of these data for three of the most frequently reported RCGs (stroke, orthopaedics, and brain dysfunction) and discusses their implications for various health care stakeholders.[11,12]

METHODS

As mentioned above, we used a survey methodology to address the research objectives. Questions pertaining to outpatient or ambulatory services available at each hospital with DRBs were added to the standard survey tool used for the *System Integration and Change* (SIC) quadrant of the 2004 data-collection phase (see Appendix A). The sample in this study was one of convenience. Ethics approval for the study was obtained through the University of Toronto Research Ethics Board.

The questions were based on previous research that examined the structure of funding and delivery of hospital-based services.[9] Because of time constraints, we were unable to pilot-test the questions with external reviewers; however, the research team reviewed the questions extensively prior to mail-out. Rehabilitation services were operationally defined only as services provided by occupational therapists (OT), physical therapists (PT), and speech language pathologists (SLP).

Participants and Protocol

Of the 211 hospitals in Ontario, only 54 have DRBs; 48 of these voluntarily agreed to participate in the *2005 Hospital Report: Rehabilitation* and were sent the SIC survey, which included the questions about ambulatory rehabilitation services. Of these 48 hospitals, 45 completed the SIC survey and 41 completed the question on ambulatory rehabilitation services (question #36), for an overall response rate of 75.9% for this study.

The SIC questionnaires were sent to a specific contact person within each participating hospital, identified when hospitals signed up to participate in the *2005 Hospital Report: Rehabilitation*.[14] These primary contact persons were individuals with a general knowledge of all hospital departments who were willing to act as main contacts for the study. They distributed the section on ambulatory or outpatient services to the person considered most knowledgeable to complete that section of the questionnaire. Questionnaires were mailed in September 2004 and returned by November 2004. Respondents were asked to complete a separate data-collection form for each of the three RCGs of interest.

Data Collection and Analysis

All returned surveys were received through the Arthritis Community Research and Evaluation Unit (ACREU), located within the University Health Network in Toronto, Ontario. The data were entered into a Microsoft Access database (Microsoft Corp., Redmond, WA) and then imported into SAS Version 8.0 (SAS Institute Inc., Cary, NC) for analysis. Frequency tabulations were performed in order to fully describe ambulatory services within this sample. Analysis of the qualitative data collected through open-ended questions is not included in this report.

Measures/Variables

As outlined in Table 1, the survey consisted of the following variables: RCGs (orthopaedics, stroke, brain dysfunction); availability/setting of services (yes/no; outpatient department, day hospital, combination); employment structure (employees, contracted out, subsidiary clinic, combinations); types of funding (public, private); access criteria (open-ended question), and wait times (open-ended question). A subsidiary clinic is defined in this study as a private for-profit clinic created within the hospital, a structure often more colloquially referred to as a ''private clinic in a public hospital.''

RESULTS

The hospitals that responded to the survey were all private not-for-profit institutions, and the majority (37/41) were independent and free-standing hospitals. In other words, the majority of hospitals in the sample were single-site facilities and were not part of larger hospital corporations with multiple locations. Moreover, participating hospitals had a combination of rehabilitation and complex continuing care (CCC) beds (39/41), and 7 hospitals had more than 100 beds (either rehabilitation, CCC, or a combination of both).[13] In the Ontario context, the term ''CCC'' is used to describe care provided in designated chronic-care beds.

Availability of Rehabilitation Services

Most hospitals reported that rehabilitation services were, to some extent, available on an ambulatory basis. Among hospitals that provided ambulatory rehabilitation services, the availability of specific rehabilitation services varied by RCG. For instance, for clients in the Stroke RCG, 90.24% of hospitals (37/41) reported that they provided PT services; 82.93% (34/41) provided OT services; and 78.05% (32/41) provided SLP on an ambulatory basis. Figure 1 shows the availability of PT, OT, and SLP services for the three RCGs (stroke, orthopaedics, and brain dysfunction) of interest in this report.

The results indicated that a large proportion of hospitals offered ambulatory PT services, as compared with OT or SLP, within all three RCGs. In the Orthopaedic RCG, there was an even greater difference in availability, which may reflect the types of rehabilitation services needed for this RCG: over 90% of hospitals offered PT services, less than 70% offered OT services, and only 30% offered SLP services. On the other hand, for the Brain Dysfunction RCG, the results indicated more similar, albeit low, proportions of hospitals offering ambulatory rehabilitation services for PT, OT, and SLP. Less than half of hospitals reported offering any ambulatory services for this RCG,

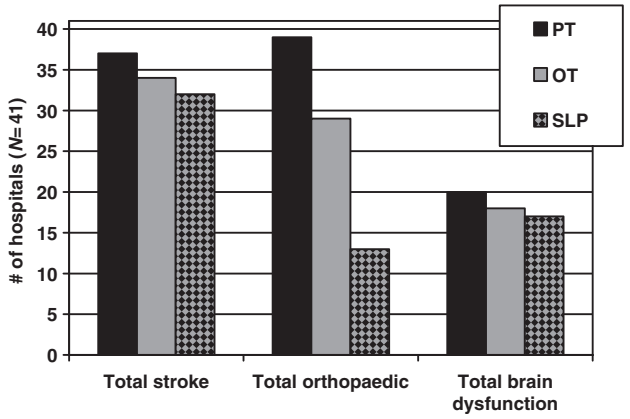

Figure 1 Availability of ambulatory rehabilitation services by RCG (OT = occupational therapy; PT = physical therapy; SLP = speech/language pathology)

probably reflecting the availability of inpatient rehabilitation programmes for conditions such as acquired brain injury (only 15 of 48 hospitals reported providing inpatient services for the Brain Dysfunction RCG).

Models of Rehabilitation Delivery

Hospitals providing ambulatory rehabilitation services generally reported delivering these services through hospital employees. Figures 2–4 report the extent to which services were delivered by hospital employees and by other market-driven ''delivery'' models, such as contracting out and creating subsidiary clinics. These figures outline delivery models according to each RCG of interest.

Hospitals that responded to this survey had a tendency to maintain the delivery of ambulatory services directly through their employees. This was particularly true for SLP: the data indicated that if SLP was offered, most hospitals provided it through hospital employees.

No hospital reported delivery of services through subsidiary clinics only; however, a very small proportion of hospitals chose to create a for-profit clinic in combination with some level of delivery by employees. Contracting out was not a strategy of choice for the participating hospitals, only four of which reported having contracted out services. When hospitals did contract out services, however, they tended to do so for all rehabilitation services (PT, OT, and SLP).

Sources of Rehabilitation Financing

Hospitals were asked to identify various public and private funding sources they accessed to finance ambulatory rehabilitation services. Public sources included global hospital budgets and Veterans Affairs Canada (VAC). Private sources included (1) motor vehicle accident (MVA) insurance, (2) the Workplace Safety & Insurance Board (WSIB), (3) third-party extended health insurance (Ext Health), and (4) out-of-pocket payments.

In the case of the Stroke RCG, respondents identified a variety of funding sources for PT services. Overall, all hospitals reported using the global hospital budget to

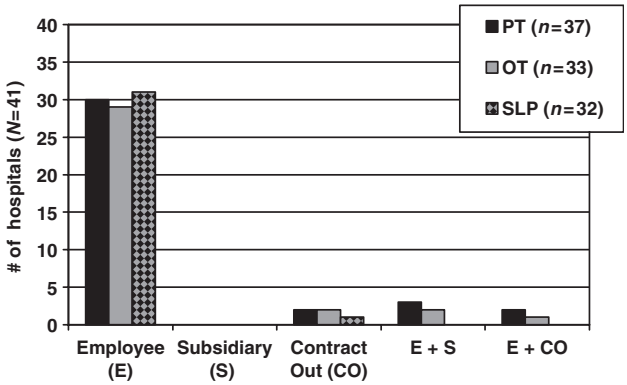

Figure 2 Models of delivery of ambulatory rehabilitation services for total stroke (OT = occupational therapy; PT = physical therapy; SLP = speech/language pathology)

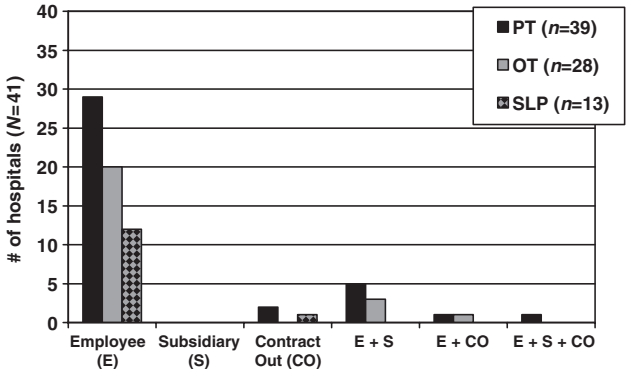

Figure 3 Models of delivery of ambulatory rehabilitation services for total orthopaedics (OT = occupational therapy; PT = physical therapy; SLP = speech/language pathology)

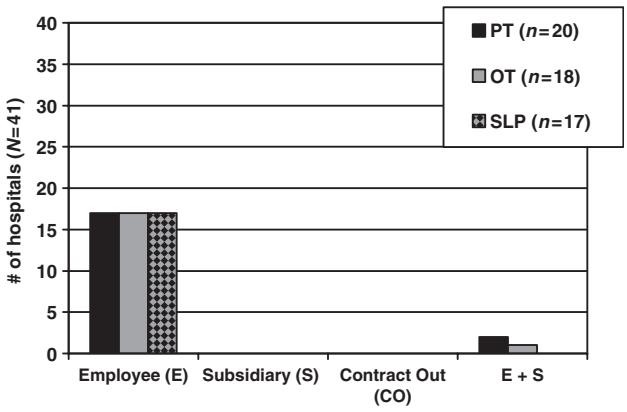

Figure 4 Models of delivery of ambulatory rehabilitation services for total brain dysfunction (OT = occupational therapy; PT = physical therapy; SLP = speech/language pathology)

fund ambulatory rehabilitation services while using other funding sources to supplement the global budget funding already received. For example, 10 hospitals reported using WSIB funding; 7 accessed MVA and extended health insurance. Funding for OT services for the Stroke RCG was varied. Global budget was again used by all hospitals, followed by 10 hospitals who also used WSIB and 6 where clients paid directly out of pocket. The trends for SLP were similar: all hospitals used global budget funding for SLP services, supplemented by WSIB and MVA sources.

DISCUSSION

The three major findings from this study have been grouped under the headings of access, delivery, and funding.

Access

Our results demonstrate that most hospitals surveyed provided some degree of ambulatory rehabilitation services. However, the availability of these services varied across the three professional service groups, with PT services generally more available across all three RCGs of interest. This is particularly true of the Orthopaedic RCG, for which over 90% of hospitals provided ambulatory PT services. By contrast, less than half of hospitals reported providing ambulatory services to the Brain Dysfunction RCG. As mentioned earlier, ambulatory services are not necessarily an insured service under the CHA, and thus hospitals can choose not to fund or deliver them. The findings of this study indicate that the majority of hospitals surveyed have maintained some level of ambulatory care and, as mentioned above, mostly for PT services.

The settings in which ambulatory services were made available by the participating hospitals demonstrated a consistent pattern across all disciplines and across all RCGs. The study findings suggest that, among hospitals with DRBs, there is a high propensity to deliver these services in either an outpatient department or through a combination of outpatient and day hospitals; in very few instances were day hospitals alone reported as the setting. The respondents in this study did not offer insight into their reasons for choosing one setting over another; as a result, the rationale underpinning such decisions is not clear. Further research is required to explore the decision-making process used to choose among these different options.

Other research has indicated that the current supply of rehabilitation services is well below optimal levels.[15] It might be reasoned that alignment between scarce resources and demand for rehabilitation, especially in ambulatory settings, will emerge as a critical policy issue as Ontario implements its health transformation agenda.

Delivery

Despite the existence of a few public/private delivery models, the overall findings indicate that the shift toward private for-profit delivery models, such as contracting out and subsidiary clinics, has not been widespread among hospitals with DRBs. Based on the results of this study, when services are available, they are generally provided through employees working in hospital outpatient departments. This finding suggests a preference for maintaining the status quo in terms of employment structures for rehabilitation professionals in Ontario hospitals with DRBs. Neither contracting out nor creating internal for-profit subsidiary clinics within hospitals appears to be widespread within participating hospitals; in fact, less than 10% of outpatient settings were contracted out to external providers. Similarly, less than 10% of hospitals reported having created subsidiary clinics. Although subsidiary clinics and contracting in general appear to be uncommon, there is a higher propensity to choose these options for PT and OT than for SLP.

Ontario's matrix of rehabilitation delivery represents multiple public and private for-profit and not-for-profit models of delivery.[16,17] The operational definition of public delivery is that services are delivered through facilities directly owned by a government (federal, provincial, or local), whereas private for-profit delivery involves a private enterprise that operates with the goal of creating profit. Private not-for-profit delivery is different than either public or private for-profit delivery in that it theoretically operates on a cost-recovery basis and does not distribute profit to shareholders or other such entities directly or indirectly associated with the corporation.[4,9] Approximately 95% of hospitals, for instance, are owned by the private not-for-profit sector.[7,18] Rehabilitation services delivered by hospital employees are thus considered to fall into the category of private not-for-profit delivery. However, OPA has reported that increasing numbers of hospitals across Ontario have restructured their delivery of PT services.[10] Despite the fact that changes in the public/private mix may be occurring around the world and that the restructuring process may be gaining momentum, including across Ontario, much of the rhetoric may be based on perception. As a number of researchers have noted, very few arguments either in favour of or against changes to the public/private mix can be substantiated by empirical fact.[19–26] Furthermore, researchers must explore the extent to which privatization is occurring in other types of hospitals and in different regions in Ontario and across Canada.

Our survey results demonstrate that the hospitals in the study sample have preferentially elected to deliver services through hospital not-for-profit employees and that for-profit delivery has not been widespread. Other reports[10] have identified increased numbers of private

clinics operating in hospitals, but our results do not support this conclusion. It is important to note that there may be differences between hospitals with DRBs and those without DRBs in terms of their ability or willingness to move toward private for-profit delivery. Once again, further research is required to understand these differences more fully and to determine the decision-making process involved in implementing change in public or private delivery models.

Funding

The primary source of funding for outpatient and ambulatory rehabilitation settings is the hospital's global budget (i.e., public funding). However, other private sources (e.g., WSIB, MVA) are being accessed by hospitals to finance rehabilitation services. The results of this study confirm that private sources do, in fact, finance ambulatory rehabilitation services in hospitals. Although this trend is known within the industry, it has not been well documented to date. One question not directly addressed in this study relates to the rationale used by hospitals to access multiple private funding streams for rehabilitation.

For many years, the first payer for rehabilitation services was the public stream, through global budgets in hospitals and institutions. However, our data demonstrate that hospitals are now, to some degree, accessing private funding in order to finance rehabilitation services. It is not clear whether the presence of these private financing sources (a) increases the pool of available financial resources in the ambulatory setting or (b) allows hospitals to retrench and limit their financial expenditures under the global budget, based on the assumption that some clients will access funding through other sources (e.g., WSIB, MVA). This debate, although beyond the scope of the present study, may lend support to the concern that introducing private streams of funding into a system may not necessarily increase the overall pool of available financial resources. In such a system, there is a balance between the possibility of increased resources from new streams and the opportunity for existing streams to retrench, limit, or restrict their expenditures.

Similar studies have demonstrated that once private funding is introduced into a system, it may evoke a series of responses.[1,2] Economic self-interest may encourage providers to restructure delivery in order to access more profitable clients. Landry[9] reported that hospitals in the Greater Toronto Area restructured ambulatory rehabilitation services either by limiting funding for certain services or by attempting to access more lucrative and less constraining private streams. In other words, when private funding enters a hospital's funding mix, it provides the necessary framework for the hospital to begin a process of shifting financial responsibility, suggesting that private funds do not necessarily improve access for clients unless those clients present with some form of private insurance or an ability to pay. It might be argued that the publicly funded sector is under-resourced; on the other hand, it could also be argued that the publicly funded sector is less efficient. In either case, the result of under-financing or poor efficiencies may be an inability of the publicly funded sector to meet client needs, leading to a push into private streams.

Study Limitations

Although the survey's response rate was high, our sample was one of convenience and included only hospitals with DRBs that participated in the *Hospital Report 2005: Rehabilitation* initiative. This sampling strategy limits the extent to which our results are generalizable; for instance, some hospitals without DRBs also provide ambulatory rehabilitation services, some of which have moved more aggressively toward private models.

One of the original objectives of the present study was to examine the distribution of waiting times for ambulatory rehabilitation services by funding source. Unfortunately, the homogeneity of funding sources within the resulting data set precluded such analysis. This study examined only Ontario hospitals with DRBs; future exploration of a potential relationship between waiting time and funding source might be plausible with a larger sample.

CONCLUSIONS

The majority of hospitals with DRBs across Ontario provide some level of ambulatory rehabilitation services, but this level varies widely depending on the professional services category (PT, OT, or SLP) and the RCG category. When services are available, hospital employees generally provide them directly.

This study assessed ambulatory or outpatient services provided within hospitals that participated in the *Hospital Report* initiative. In addition, the study provided a snapshot of the funding and delivery of services. Further research should examine the extent to which hospitals that do not have DRBs—the vast majority of hospitals in Ontario—vary from those included in this study. Overall, in order to more fully understand ambulatory rehabilitation services, future health services research must address these and other issues, including the relationship between specific funding sources and corresponding wait times. This study has provided the descriptive foundation on which to base future studies on hospital-based rehabilitation service delivery.

KEY MESSAGES

What Is Already Known on This Subject

Vague wording in the Canada Health Act has rendered ambulatory services in hospitals vulnerable to reform and restructuring. As a result, the debate over the extent of hospital-based rehabilitation services across provincial and territorial jurisdictions and the structure of funding and delivery of existing services continues to evolve.

What This Study Adds

All hospitals across Ontario with designated rehabilitation beds provide some degree of ambulatory rehabilitation services; however, availability varies according to discipline and across clinical conditions. Our results indicate a low propensity among the hospitals surveyed to restructure hospital-based physical therapy delivery; as a result, the majority continue to provide services directly through their employees. On the other hand, though market-driven delivery options such as contracting out have not been widespread, hospitals sampled in this study do access quasi-public and private funding in order to finance and/or subsidize service delivery.

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APPENDIX: SURVEY QUESTION #36

36. By RCG category, please indicate which professional services are **currently** available in either an outpatient department or day hospital setting, at your hospital. For each professional service available, please indicate who provides services, sources of payment and the approximate wait time for high and lower priority patients.

RCG	Professional service category	Where is the service provided? (check all that apply)	Who provides the services? (check all that apply)	What is the source of payment for these services? (check all that apply)	What are the approximate wait times?
	❑ Physiotherapy	❑ Outpatient department ❑ Day hospital ❑ This professional service is *not* provided at our hospital on an outpatient or ambulatory basis	❑ Hospital employees working in a publicly-funded department ❑ Hospital employees working in the hospital for profit clinic ❑ This hospital-based service is contracted out to an external provider If yes, which provider: _____	❑ Hospital Global Budget ❑ Veterans Affairs Canada ❑ Motor Vehicle Accident Insurance (MVA) ❑ Workplace Safety & Insurance Board (WSIB) ❑ Extended Health Insurance ❑ Patient Out-of-Pocket Payment ❑ Assistive Devices Program ❑ Other (specify); _____	1. *High-priority* patient defined as: _____ _____ Wait time: _____ 2. *Lower-priority* patient defined as: _____ _____ Wait time: _____
	❑ Occupational Therapy	❑ Outpatient department ❑ Day hospital ❑ This professional service is *not* provided at our hospital on an outpatient or ambulatory basis	❑ Hospital employees working in a publicly-funded department ❑ Hospital employees working in the hospital for profit clinic ❑ This hospital-based service is contracted out to an external provider If yes, which provider: _____	❑ Hospital Global Budget ❑ Veterans Affairs Canada ❑ Motor Vehicle Accident Insurance (MVA) ❑ Workplace Safety & Insurance Board (WSIB) ❑ Extended Health Insurance ❑ Patient Out-of-Pocket Payment ❑ Assistive Devices Program ❑ Other (specify); _____	1. *High-priority* patient defined as: _____ _____ Wait time: _____ 2. *Lower-priority* patient defined as: _____ _____ Wait time: _____
	❑ Speech Language Pathology	❑ Outpatient department ❑ Day hospital ❑ This professional service is *not* provided at our hospital on an outpatient or ambulatory basis	❑ Hospital employees working in a publicly-funded department ❑ Hospital employees working in the hospital for profit clinic ❑ This hospital-based service is contracted out to an external provider If yes, which provider: _____	❑ Hospital Global Budget ❑ Veterans Affairs Canada ❑ Motor Vehicle Accident Insurance (MVA) ❑ Workplace Safety & Insurance Board (WSIB) ❑ Extended Health Insurance ❑ Patient Out-of-Pocket Payment ❑ Assistive Devices Program ❑ Other (specify); _____	1. *High-priority* patient defined as: _____ _____ Wait time: _____ 2. *Lower-priority* patient defined as: _____ _____ Wait time: _____